ACADEMY ON VIOLENCE & ABUSE

ADVANCING HEALTH EDUCATION & RESEARCH

AVA Research Reviews provides AVA members with recent published, peer-reviewed articles in a broad array of violence and abuse topics. The goal is to highlight and disseminate violence and abuse research in a timely fashion, and to enhance healthcare providers' practice by fostering the educational mission of AVA

AVA Research Review

ADVANCING HEALTH EDUCATION & RESEARCH

Review Title: Does primary care identification of women experiencing intimate partner violence increase referrals?

Reviewer: Kelsey Hegarty MBBS, PhD, Associate Professor, The University of Melbourne, Australia

Article:
Feder G, Agnew Davies R, Baird K, et al. Identification and referral to improve safety (IRIS) of women experiencing domestic violence: a cluster randomised controlled trial of a primary care training and support programme. Lancet 2011; October 13, DOI: 10.1016/S0140-6736(11) 61179-3

Article Summary:
Brief Overview:

Controversy continues about the best way to identify and respond to women experiencing intimate partner violence in primary care. Evidence is extremely limited from the primary care setting as to whether training practitioners to case find women (based on typical presentations in primary care) can make a difference to referral patterns or to women's lives.

What follows is a summary of a recent UK research trial which robustly tests case finding and referral for advocacy. A 2009 Cochrane review (by the same research group) showed that intensive advocacy for abused women may reduce physical abuse, although most of the trials examined in the review were from women who had sought help from refuges or shelters.

Aims of the Feder article:
A cluster randomised controlled trial testing whether an educational and systems primary care intervention improved identification and referral for women experiencing intimate partner violence.

Relevant findings:
Feder and colleagues show, in a very well designed trial, that an intensive primary care training intervention can dramatically increased the documentation of intimate partner violence by general practitioners (or family doctors) and significantly increased referrals to specialist advocacy services.
Importantly, there were no adverse events recorded.
Across each practice (of around 3000 patients), disclosures of abuse increased from five women in the control group to 25 women in the intervention group. For the total of around 70,000 patients, the recorded referral difference was from a low level of 0.02% in control to 0.3% intervention group. In the authors' words, the 24 intervention practices recorded 223 referrals of patients to advocacy and the 24 control practices recorded 12 referrals (adjusted intervention rate ratio 22·1 [95% CI 11·5-42·4]). Intervention practices recorded 641 disclosures of domestic violence and control practices recorded 236 (adjusted intervention rate ratio 3·1 [95% CI 2·2-4·3).

Authors' conclusions:
Primary care staff who received a training and support programme improved referral to specialist domestic violence agencies. Further, recorded identification of women experiencing intimate partner violence was increased indicating that screening of women patients is not a necessary condition for improved identification and referral to advocacy services.
Potential Limitations of the findings:
The main potential limitation of the findings is that there was a very low baseline of referrals and it is not known whether the statistical significance of the increase from this low baseline translates into clinical significance for women i.e. were the women any safer, happier or healthier. The researchers have used a proxy outcome of referral and did not measure through surveys any women's outcomes such as safety, quality of life or mental health. Further, it is difficult to assess whether referred women received evidence-based interventions from the domestic violence service sector.

Reviewer's comments:
These findings do tell us that educating primary care clinicians to identify through case finding can result in an increase in referrals to domestic violence advocacy and potentially improve women's mental health and quality of life. Do we know whether the small increase of women referred for advocacy would translate into better outcomes for those women? The answer is uncertain, but based on the Cochrane review we could presume that the advocates are providing evidence based response that does improve outcomes. However, additional research is needed to find out more about women who are referred to domestic violence services from primary care. Further evaluation is needed as the evidence on advocacy is mostly from women who have sought services independently of primary care referrals.

This study (using a case finding approach vs. universal screening) demonstrated positive results, and contrasts with current findings that do not support primary care screening as discussed in a recent AVA research review (vol. 11, Nov 2012).
This trial is a complex multifaceted intervention, requiring prompts in the medical record to ask about abuse, practice champions, whole of practice training (4 hours clinicians, 2 hours adminstrators), a simple referral pathway to specialist advocacy support, feedback on referrals and reinforcement over the year. The transferability of the intervention to other health systems requires availability of computerised medical records and advocacy referral options,

which are lacking in many low to middle income countries.

To date there have been no trials comparing the two major responses proposed (screening for intimate partner violence and case finding in health settings), with both having only been minimally evaluated in robust randomised controlled trials. This rigorous case finding trial advances our knowledge about the intervention intensity that is required to change clinician's behaviour and with a resultant change in their documentation of intimate partner violence and referral behaviours.

There is a promising potential for further knowledge to be gained through careful process evaluation and evaluation of any subsequent roll out of the intervention in the UK and other countries. A replication randomised controlled trial is planned in Australia. We will await further case finding trials to help us answer questions about whether such training will make a difference to women and children's lives.

In addition, we need more evidence about the effect on abused women's children's outcomes and careful quantitative and qualitative evaluation of the harm/benefit of any interventions for women and their children. Insufficient evidence is presented in many trials about what women think about being identified and referred. Many women are not ready to engage with primary care clinicians or accept referrals for a whole range of reasons including not being ready to label their experiences or name the abuse, controlling behaviour on the part of the partner, or that they have already sought help elsewhere.

Feder's group in the UK are doing careful and systematic inquiry into how primary care can assist a range of women who attend primary care to live healthier and safer lives.

The strength of the IRIS trial is in the collaboration with domestic violence prevention advocates who were a key part of the intervention. This collaboration will only improve violence prevention researchers' abilities to design effective interventions.

Conflicts of interest:

Kelsey Hegarty received an honoraria, travel and accommodation payments from University of Bristol in 2011 as a visiting Professor.